STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP)
Final PCMH Application for Cohort 3

Version 1.0 FINAL (August 2017)

A Final Application **must be completed** *online* for each individual clinic site **by Friday, October 13, 2017**, to be considered for SHIP participation. If you encounter content or technical issues, please contact the Office of Healthcare Policy Initiatives at OHPI@dhw.idaho.gov or call 208-334-0600.

Introduction: The Idaho SHIP seeks to transform the healthcare system through use of a state developed model test design based on the Patient Centered Medical Home (PCMH) model of care. Continuing the healthcare reform process Idaho initiated in 2007, the Idaho Healthcare Coalition (IHC) was created by executive order 2014-02 to lead this process and guide Idaho's SHIP. As part of the grant, Idaho has the ability to support practice transformation with a variety of resources and tools (e.g. technical assistance, data analytics tool, incentive payments). Idaho's transformation plan is based on our experience and success with the patient centered medical home model.

This final PCMH application will be used to evaluate and determine the third cohort of clinics selected for SHIP participation. As guided by the IHC, selection criteria are based on key transformation standards and elements thought to increase the chance of successful PCMH implementation and potential recognition. These criteria in no specific order include: physician/ provider champion engagement, geographic location (within each of the seven Public Health Districts), rural vs. urban/suburban service area, electronic health record utilization and connectivity, and PCMH familiarity. The criteria selected have been based on previous experience implementing the PCMH model within the state of Idaho and our desire to select clinics able to make the transformation successfully.

Previous experience with clinic recruitment has also taught us to collect selection criteria items as well as readiness assessment information during the application process. This permits readiness information to be shared with the SHIP PCMH technical assistance contractor after final cohort selection, allowing them to enter work with this cohort better informed of the current structure. **Selection criteria question text will appear in BOLD**, while readiness assessment questions will remain in plain text format. Questions contained within this application are logic driven; meaning that depending on how questions are answered, additional questions will appear seeking further details. Please respond to all questions honestly and as accurately as possible; answers provided to readiness assessment questions will not be viewed or considered by the Department evaluation team. The selection committee will receive de-identified responses when reviewing applications for participation.

Finally, SHIP is a multi-year plan for Idaho that includes three cohorts of clinic selection. Cohort 1 spanned from 2/1/2016 to 1/31/2017; Cohort 2 began 2/1/2017 and will end 1/31/2018. Cohort 3 will span 2/1/2018 to 1/31/2019. Final notification of clinic selection for Cohort 3 is anticipated to occur during the month of December 2017; additional instruction and next steps will be provided at time of notification.

The number of clinics selected is directly tied to grant resources, funding and current change capacity.

Additional information on SHIP including a FAQ page can be found on our website at: www.SHIP.idaho.gov.

Section 1: Clinic Profile

Rationale:

Your clinic contact information, make-up and descriptive characteristics will assist in follow-up efforts and does include several **selection criteria** (**BOLD** items)

Please provide the following information for each individual clinic site to be considered for SHIP participation:	
1. Clinic Name	
2. Clinic's Physical Address	
3. City *[SELECTION CRITERIA]*	
4. State	
5. County *[SELECTION CRITERIA]*	
6. Zip Code *[SELECTION CRITERIA]*	
7. Phone Number	
8. Fax Number	
9. Main Contact First Name	
10. Main Contact Last Name	
11. Main Contact Email Address	
12. Corporate Ownership or Healthcare System Name (if applicable)	
13. Organization Type *[SELECTION CRITERIA]*	☐ Private Practice ☐ Community Health Center (CHC)/ Federally Qualified Health Center (FQHC) ☐ Rural Health Clinic (RHC) ☐ Hospital/ Health System Owned Clinic ☐ Other:
14. Predominant Specialty *[SELECTION CRITERIA]*	☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ Multi-Specialty ☐ Other:

15. Please complete the Clinic Staff List	a. Physicians		
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time

			☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time

b. Physician Assistants, Nurse Practitioners			
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time

c. Clinic Staff (i.e. other professional licensed staff)			
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time

d. Administrative and Support Staff			
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time
	Name:	Credentials:	☐ Full-time ☐ Part-time

Section 2: Transformation Plan, History and Experience

Rationale:
Through various pilot projects, we have learned engaged leadership and an effective transformation team are critical to the success of implementing and sustaining the PCMH model. Questions appearing in **BOLD** will be considered as selection criteria.

16. Please list your current or proposed Transformation Team members	Physician/ Provider Champion Name:	Title:	Role in Transformation:	email:
	Clinic Administration Name: (if applicable)	Title:	Role in Transformation:	email:
	Office Manager Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
17. Has your clinic ever participated in any of the following? *[SELECTION CRITERIA]* (Please check all that apply)	☐ Safety Net Medical Home Initiative ☐ Idaho Medical Home Collaborative (IMHC) Pilot ☐ Oregon's PCPCH Program ☐ Other PCMH Programs (CHIC, Medicaid Health Home Program, etc.); Please list: ☐ None			
18. Has your clinic achieved national PCMH recognition or accreditation? *[SELECTION CRITERIA]* *Recognition is encouraged, but not required to apply or to participate in the SHIP.*	☐ Yes [if yes, proceed to 19, skip 20-21] ☐ No [if no, proceed to 20]			
19. Please indicate, the organization(s) the national PCMH recognition or accreditation was received from, and level of recognition (if from NCQA). *Recognition is encouraged, but not required to apply or to participate in the SHIP.*	☐ AAAHC Date Accredited: ☐ Joint Commission Date Accredited: ☐ NCQA Date Recognized: Level of Recognition: ☐URAC Date Certified:			

20. Are you currently in the process of applying for recognition or accreditation with AAAHC, The Joint Commission, NCQA, or URAC?	☐ Yes [if yes, proceed to 21] ☐ No [if no, proceed to 22]
21. Please provide information on the status of your application process for national recognition or accreditation, with which organization you are applying, and to what level, if applicable, you are attesting to?	

Section 3: Health Information Technology (HIT) Capabilities

Rationale:
We understand that every clinic in Idaho has a different level of experience and may use one of several platforms (i.e. EHR). Access to data, in a timely and consistent manner is essential for effective practice transformation. Additionally, federal grant reporting requirements necessitate practice connectivity to the Idaho Health Data Exchange (IHDE) and Health Tech Solutions. Many of the questions included in this section are readiness related and will assist the IHDE once the first wave selection has been completed. Only questions appearing in **BOLD** will be considered as selection criteria. The questions in this section should be answered by or through consultation with your clinic's IT Administrator/ Manager.

22. Does your clinic have an electronic health record? *[SELECTION CRITERIA]*	☐ Yes [if yes, proceed to 23] ☐ No [if no, proceed to 36]
23. Do you have an EHR conversion planned or being considered between 2/1/2018and 1/31/2019? (For example: Will you be changing EHR vendors or software between 2/1/2018 and 1/31/2019?) *[SELECTION CRITERIA]*	☐ Yes ☐ No
24. Please identify your clinic's IT Administrator/ Manager or anyone in your clinic who is involved in the daily operational management with your EHR vendor and the person completing the questions in this section of the application.	IT Contact Name | Title | Organization (if not employee of applying clinic) | Email | Phone |
25. Did the person listed in Question 24 complete this section of the application?	☐ Yes [if yes, proceed to 27] ☐ No [if no, proceed to 26]
26. If No, please identify the person completing this section of the application	Name | Title | Email | Phone |
27. What is the size, make-up, and availability of your clinic's IT office staff?	
28. Who is your EHR vendor?	☐Allscripts Professional ☐athenaClinicals ☐Centricity ☐Cerner ☐e-MDs ☐eClinicalWorks ☐Epic ☐Greenway (PrimeSuite, SuccessEHS, Intergy) ☐NextGen ☐McKesson (Practice Partner) ☐Meditech

	□ Other (please specify):
29. What EHR software version is currently deployed to production? (This can often be located on the splash screen of the program when launched)	
30. How many months has the clinic been using its current EHR system?	
Note: For questions 31-33, please contact your EHR vendor to confirm prior to responding:	
31. Does your EHR support Health Information Exchange (HIE) connectivity? (Not all EHR products support this capability. You may need to contact your EHR vendor for assistance in answering this question) *[SELECTION CRITERIA]*	□ Yes □ No
32. Can your certified EHR produce a CCD (transition of care document) in the .xml format using the CCDA template structure? (You may need to contact your EHR vendor for assistance in answering this question)	□ Yes [if yes, proceed to 33] □ No [if no, proceed to 34]
33. If yes, can your EHR automate the production of the CCDs, as opposed to having to manually create them? (You may need to contact your EHR vendor for assistance in answering this question)	□ Yes □ No
34. Do you have access to vendor product support? (Often referred to as 'Level 2' support - troubleshooting, configuration, database administration, and repair for server, network, infrastructure, Data Center, email, file shares, and other infrastructure issues)	□ Yes □ No
35. Do you have access to helpdesk support when you have questions about your EHR? (Often referred to as 'Level 1' support – device support, breaks/fixes, configuration issues, software installations, trouble shooting)	□ Yes □ No
36. How does your clinic or organization support your EHR product?	
37. Is your EHR currently connected to the Idaho Health Data Exchange (IHDE)?	□ Yes □ No

Section 4: Primary Care/ Behavioral Health Integration

Rationale:

Idaho is a 100% designated shortage area for mental health professional services. As clinics transform to PCMH practices support the client, integration and access to behavioral health care will be essential elements to achieving patient wellness. Part of the SHIP plan includes goals and metrics related to increasing patient wellness and this will be support in part by behavioral health integration efforts with PCMH clinics.

38. Please indicate the level of primary care/ behavioral health integration occurring in your office?	☐ Full collaboration in a merged integrated practice for all patients ☐ Close collaboration with several aspects of integrated practice ☐ Co-located with close collaboration on-site with some system integration ☐ Co-located with basic collaboration on-site ☐ Basic collaboration off-site ☐ Minimal collaboration/ coordination
39. Is your clinic completing behavioral health screenings (i.e. a PHQ 2, PHQ 9, or other universal screening)?	☐ Yes [If Yes, proceed to 40] ☐ No [If No, proceed to 41]
40. If yes, are behavioral health screenings conducted only during wellness visits?	☐ Yes ☐ No
41. Please describe how your clinic interfaces with behavioral health services and providers in your community. It can include efforts to meet patients' needs not previously captured.	

Section 5: Quality Improvement (QI) Activities

Rationale:

Quality improvement is a hallmark of high performing patient centered medical homes. Learning more about current practices will assist the PCMH contractor in offering technical assistance.

42. Does the clinic use performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience?	☐ Yes ☐ No		
43. Do you have a formal quality improvement policy in place?	☐ Yes [If Yes, proceed to 45] ☐ No [If No, proceed to 44]		
44. If No, do you have a plan to implement QI policies and procedures?	☐ Yes ☐ No		
45. Please indicate frequency of QI meetings.			
46. Please list clinic role of QI committee members (e.g, RN, patients, office manager)	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
47. Please specify the QI tool(s) being used by your clinic (e.g. Six Sigma, Lean, PDSA cycles).			
48. Please indicate what you track and measure. (Check all that apply)	☐ Clinical Quality measures ☐ Preventive care ☐ Care Coordination ☐ Patient Experience ☐ Provider Experience ☐ Overall clinic efficiencies affecting healthcare costs (e.g., reduction readmissions, ER visits, redundant labs)		

Section 6: Clinic Vision and Intentions

Rationale: An engaged physician/ provider leadership champion, clinic administration engagement and a dedicated transformation team is imperative for successful transformation and sustainability of the PCMH model. A physician (recommended), or other provider leadership champion, should be instrumental in implementing long-term changes/vision and continually encourages other physicians/providers who might be unsure if they want to participate.	

49. How does your clinic's strategic plan align with the SHIP goals to improve health outcomes, reduce healthcare costs and improve provider and patient experience?	
50. **Please tell us about your identified physician/ provider champion [answered in Section 2; Question 16] and what your transformation team hopes to accomplish within the Cohort 3 timeframe (February 1, 2018 to January 31, 2019) and beyond.** *[SELECTION CRITERIA]*	
51. **As the physician/ provider champion for this clinic, what will your commitment to this PCMH work look like over the next year (i.e., attending meetings, leading communications, breaking down barriers, troubleshooting challenges, etc.)?** *[SELECTION CRITERIA]*	
52. **As the physician/ provider champion for this clinic, please describe:** • **One or more successful change or transformation projects you have championed within the clinic.** • **How did you champion that change?** *[SELECTION CRITERIA]*	

Section 7: Completion & Submission

By electronically submitting this application, I attest the answers provided are complete and accurate to the best of my ability at the time of submission.

Further, I attest that I am the authorized representative of the business entity permitted to submit this application for consideration.

Name of person completing application	
Job Title	
Email address	
Phone number	